If we are not healthy, we cannot be the best husbands, fathers, or productive citizens that are vital to help keep our society going. Today, men suffer from some alarming health statistics. It is common knowledge that heart disease is the leading cause of death among men in the United States.

The life expectancy of men is much lower than that of women by at least 7 years. Currently men represent 84 percent of all AIDS cases in the United States. In the African-American community, HIV/AIDS is spreading like wildfire. A recent survey revealed an increased infection rate of 4.4 percent for young gay men. The rates ranged from 2.5 percent all the way up to 14.7 percent among gay black men. In Chicago alone, gay men account for 53 percent of HIV/AIDS cases. Public health officials say that they are seeing disturbing trends of reckless behavior.

Another sad statistic is the mortality rate for African Americans from all types of cancer. It is 68 percent higher than for any other group. There are many other types of ailments that afflict us, such as high blood pressure, stroke, diabetes, excessive accidents on the road.

Well, as one can see very well, the problems are there. The odds seem to be against men. But I assure my colleagues that an ounce of prevention is worth much more than 1,000 remedies.

So I would urge all men not to wait until it is too late to bring into our lives the proper balance of health care. We can all have a better life. If that is not possible, we can all certainly make life more bearable.

I urge all men to take time to reflect on the value of your life, on the well-being of yourself, and the ripple effect that it can have on all of the roles that you play and the lives of all the people with whom you come into contact. Should your health, your state of mind, your stress level or anything else be of concern that requires attention, please consult your physician, seek assistance at your earliest convenience.

Let us celebrate Father's Day in good health as we celebrate this week dedicated to improving the health, not only of all of our citizens, but especially the health of men who oftentimes do not look or pay as much attention to themselves.

I also take this opportunity, Mr. Speaker, to indicate support for the efforts and activities of individuals, organizations, institutions and other entities that are designed to honor fatherhood on Father's Day, especially when we look at statistics which suggest that children who are raised without their fathers account for 63 percent of youth suicides, 71 percent of pregnant teenagers, 90 percent of homeless and runaway children, 85 percent of behavior disorders.

As my colleagues can see, Mr. Speaker, all of these problems are seriously affecting not only the lives of individuals, but the lives of people in our country.

HEALTH CARE AND PRESCRIPTION DRUGS

The SPEAKER pro tempore. Under the Speaker's announced policy of January 3, 2001, the gentlewoman from Ohio (Mrs. JONES) is recognized for 60 minutes as the designee of the minority leader.

Mrs. JONES of Ohio. Mr. Speaker, on behalf of my colleagues, we wish to discuss the whole issue of health care this evening. Particularly we are going to be discussing the issue of prescription drugs.

We anticipate that, over the next few years, prescription drug use will increase with age along with the prevalence of chronic and acute health problems. Over 13 million Medicare beneficiaries have no drug coverage whatsoever, and over three in five beneficiaries have undependable drug coverage.

The Federal Health Insurance Program that covers 40 million elderly and disabled Americans does not cover outpatient prescription drugs. Ten million Medicare beneficiaries have no drug coverage at all.

According to HCFA, the national spending on drugs has tripled in the last decade, and it is expected to more than double between 2000 and 2010 from an estimated $172 billion to $366 billion.

Medicare beneficiaries account for 14 percent of the United States population, but 43 percent of the Nation's total drug expenditures. Medicaid provides drug coverage for 12 percent of the Medicaid population, generally those with very low income. Only half of all the Medicare beneficiaries with incomes below the Federal poverty line are covered by Medicaid.

In 1998, Medicaid spent on average $893 per elderly beneficiary for pharmaceuticals. Medicare HMOs assisted 15 percent of all beneficiaries with their drug costs in 1998, although the share dropped to about 10 percent in 2001. Virtually all Medicare beneficiaries use pharmaceuticals on a regular basis and fill an average of 22 prescriptions per year.

In 2001, the average annual out-of-pocket spending for drugs among Medicare beneficiaries is estimated to be about $858, with 27 percent of beneficiaries expected to spend more than $1,000. Medigap provides prescription drug benefits to approximately only 10 percent of all the Medicare beneficiaries.

I listed all of these prescription drugs statistics particularly to focus in on the fact that, across this country, there are senior citizens and others who are in a dilemma without having any type of prescription drug benefit.

Mr. Speaker, I would like to kind of engage in a colloquy with the gentlewoman from Florida (Mrs. THURMAN), who has been very active in the forefront on the issue of prescription drug benefits.

Mr. Speaker, I yield to the gentlewoman from Florida (Mrs. THURMAN) to discuss what she has been seeing that has occurred in the State of Florida on this issue.

Mrs. THURMAN. Mr. Speaker, if one can imagine, in Florida a high percentage of our seniors are in the Medicare program because we have a very high senior population. You know what I have found is interesting over the last couple of years, we have had this issue on the table. This issue is being talked about. It has been massaged. It has been looked at. We have tried to bring it to the forefront of any debate that has happened in this Congress because of exactly what the gentlewoman has put in her remarks, what is happening out there.

I think that any of us that has had any kind of work done, that one of the first issues that we have to look at is how do we make sure that the people in this country are getting the same medicines at the same cost as other countries. I do not want to hear, well, it is about research, because we hear it is about marketing research, and we have all seen the ads.

So we did, a couple of years ago, just a kind of analysis of what was happening in our State and in my district in particular, in the Fifth District, and we found out that, for the most part, life-sustaining drugs, not just fun drugs or something that was not life-sustaining, but drugs that seniors had to take actually were costing overall about 125 percent more than they were in actual programs like Medicare+Choice or prescription drug benefit under some Medigap programs or whatever.

Now, also, then, we went a little bit further; and we said, well, let us look at other countries and what is happening. We looked at our border countries like Mexico and Canada. Then of course when we started looking at that, and the information started coming up to the seniors in this country, guess what happened? They decided that they needed to go over the border to buy their medicines because they could get them at half of what we were paying for them in the United States.

Then we went a little bit closer in, and we found the same kind of thing happening in the European nations where they, too, were getting medicines for a lower cost.

Mrs. JONES of Ohio. Mr. Speaker, the gentleman from Ohio (Mr. BROWN) in Lorain took two or three busloads of seniors up to Canada because they were able to purchase their prescriptions at a significantly lower cost than they were able to have purchased them in the United States.

Mrs. THURMAN. Mr. Speaker, saying that, we had the same thing happening

up in Vermont, in Maine, where they also went up on bus trips.

What is interesting is the States have recognized the potential problem or the problem they are having, and State legislatures were getting a lot of pressure put on them to change their laws and, in fact, did in some of these legislatures say that the pharmaceutical companies could not charge more than what they were paying for or what they were getting in Canada or their border state, which was, quite frankly, something that I think that a lot of Americans need to know about because we could do that here.

In fact, there is a piece of legislation this year, the Allen bill, and there are several of us that are on that, that actually would say that.

We need to look at the cost and what it is costing Americans as to what it is costing not only our border states, but other countries around us. We think we could save about 40 percent of the cost without doing any benefit, without costing one dime from the Federal Government. I mean, you would not even have to put out a charge there. All you would have to do is say we think that if you can sell it for this amount over here, then why should not we be given the same benefit in this country. Well, and that is just one thing.

Now we have another issue going on that actually we have had some U.S. Senators that have introduced it, along with the gentleman from Ohio (Mr. BROWN), who the gentlewoman from Ohio (Mrs. JONES) mentioned, who took the lead in this; and it was based on what I call stacking, which was actually a part of a program, one of the news programs at night was talking about. I just thought this is crazy. I mean, here we are again watching the same thing over and over and over again.

We have this thing called patents, and patent laws protect the name brand medicine for about 20 years. Then the patents are let go; and, as we know, then we get what is called a generic drug, which by the way costs a lot less. The gentlewoman from Ohio mentioned the difference, I believe.

Mrs. JONES of Ohio. I did, Mr. Speaker.

Mrs. THURMAN. Mr. Speaker, maybe the gentlewoman can tell me those numbers again, but how many people have dropped off Medicare+Choice programs that no longer had prescription drugs where they did before. Is it twelve?

Mrs. JONES of Ohio. Mr. Speaker, over 13 million Medicare beneficiaries have no drug coverage. Over three out of five beneficiaries have undependable drug coverage. Right.

Mrs. THURMAN. Mr. Speaker, so now what is happening, and what I found in some of this work that I have been doing, is that in some of these Medicare+Choice programs, not only are they dropping a lot of their prescription drug coverage, but in some cases they will only cover generic drugs.

□ 1915

Mrs. JONES of Ohio. And if the drug they need is not at the status of being a generic drug, then these people are really in a dilemma.

Mrs. THURMAN. They have no coverage now.

Mrs. JONES of Ohio. At all.

Mrs. THURMAN. So what happened is, all of a sudden now there is this information coming out to us that drug companies, or pharmaceutical companies, are able to extend their patents, I cannot even believe why, would extend the patents probably somewhere around 2 to 3 years, creating the idea that then the generic drug never becomes available for that long. And that also causes a problem because we could cut or look at the cost.

Mrs. JONES of Ohio. The interesting thing is, and I think that everyone on our side of the aisle wants to be clear that we are not trying to bankrupt any of the drug companies. We thank them for the research that they have done in this particular area.

Mrs. THURMAN. Absolutely.

Mrs. JONES of Ohio. And the advancement in medicine that has been made. But the reality of it is that there are people across our country that cannot afford to purchase the drugs at the costs that are currently set; and we really need an opportunity to spread the wealth, to allow those who are unable to afford that high cost to participate as well.

The gentlewoman was talking about the studies that were done in the State of Florida. We did a study in my congressional district; and there was one drug, that I wish I could remember the name as I stand here right now, that seniors were paying 1,000 over the cost if they were in a favored status plan.

Mrs. THURMAN. It actually is a hormone, and it actually was something that sometimes we need to keep ourselves in balance.

Mrs. JONES of Ohio. Correct.

Mrs. THURMAN. A lot of people understand that. Even our husbands would understand that on occasion.

Mrs. JONES of Ohio. Absolutely.

Mrs. THURMAN. And that was one of those issues that in fact raised the level of it, and it causes a lot of problems for some people.

But on this generic thing, I think there is something else that needs to be remembered. This is not just about seniors at this point. This is families. This is children. This is young, this is middle-aged, and this is the older generation. Everybody benefits when we have a generic drug. And the numbers that we looked at were that it actually could save about $71 billion for this whole group of folks, whether it was families or whatever. Think about $71 billion.

Mrs. JONES of Ohio. And the thing that is so important is that we have as a Nation now developed our health care in a delivery system where we can engage in preventive health care. And if we could engage in preventive health care with certain prescription drugs, then we could really save ourselves dollars on the other end of the lifeline. We need to be able to provide the necessary prescription drug benefit to people at an early age, to keep them from getting themselves in harm's way.

One of the prevalent conditions that exists across the country is the whole issue of diabetes and trying to reach diabetes at an early age so individuals do not develop to the level where they have to take insulin, which is much more costly than watching your diet and taking some type of prescription. That would be significant in all families.

Let us even take a look at the gentleman from Illinois (Mr. DAVIS), our colleague, who was talking earlier about the whole issue of prostate cancer and having the ability to do the diagnosis, the preventive care, the type of prescription drugs to be able to arrest that situation early on and to give advice and counsel. That would be significant.

Mrs. THURMAN. The gentlewoman brings up an excellent point, and it is a point that needs to be talked about even more. As we just did the tax bill, and we are watching all these dollars kind of go out there right now, which legitimately we all agree there should have been a tax bill, we just think it should have been a little more reasonable.

Mrs. JONES of Ohio. And to allow for prescription drug benefits.

Mrs. THURMAN. Right, and the fact of the matter is that within that there is also the situation we are in now with Medicare and dollars that we have available and what is going to happen in 10 years from now when the baby boomers come in and we have this huge exploding price. Well, one of the ways, and the gentlewoman is exactly right, that we can look at the expenses is by prevention.

Well, this is what happens under Medicare. If a person is ill, an elderly person, and we have heard the stories.

Mrs. JONES of Ohio. Over and over.

Mrs. THURMAN. People would cry if they heard some of the letters I have gotten as we have started talking about this: wives saying I cannot take my medicine any more because my husband needs it more; or I can only take it half the time. Guess what happens? These folks end up in the hospital. They end up in the hospital; and now we have Medicare, which, in fact, as the gentlewoman pointed out, pays for inpatient medicines. So they pay

for the inpatient medicine. So we get the person healthy, or as healthy as we can.

Mrs. JONES of Ohio. Under the circumstances.

Mrs. THURMAN. Under the circumstances. And we kind of get them out there; and then we say, okay, now, go home. They go home and they have their prescription drug from their doctor, and they go to the pharmacy and all of a sudden we have got them in balance now. They are feeling a little better. They go to the pharmacy and what happens? The first thing that happens is they are standing there, and they may be looking at a $300 bill, a $200 bill, an $800 bill, going, I cannot afford this. They buy what they can, they work with the pharmacist, they cut them in half, and 3 or 4 months later, guess what happens? They end up back in the hospital. And Medicare is paying for that.

Mrs. JONES of Ohio. I cannot forget that, in the course of my decision to come to Congress, I was engaged in a town hall meeting; and one of the people in the audience says, Well, why don't you buy every constituent in your district a pill cutter? I said, do what? Buy them a pill cutter, and then they could cut up the pills that they have and it would extend over a longer period of time. I said, Sir, the real reason I won't buy one is I am not a pharmacist or a doctor. And how can I tell a constituent of mine how much medicine to take and when they should take it? That is why we license doctors to prescribe and why we license pharmacists to dispense on the prescriptions.

I could not believe it. But the reality is that we do have people across this country who have gotten pill cutters and started thinking that they can self-prescribe by saying, well, instead of taking one pill today, I will cut it in three and take it three times in a day and really not understanding how different prescriptions interplay with one another and the impact they can have on their health long term.

We have been joined by our colleague, the gentleman from New Jersey (Mr. PALLONE), who is actually our leader on this particular issue.

Mr. Speaker, can I get a ruling from the Chair as to how I would now turn this time over to the gentleman from New Jersey (Mr. PALLONE) so I will not cause us to lose this time, please.

The SPEAKER pro tempore (Mr. GRUCCI). On the designation of the minority leader, the balance of the pending hour is reallocated to the gentleman from New Jersey (Mr. PALLONE).

Mrs. JONES of Ohio. As I leave, Mr. Speaker, I would like to say that it has been wonderful to have an opportunity to engage in a colloquy with my colleague, the gentlewoman from Florida (Mrs. THURMAN). She has been a leader in this area.

Mr. PALLONE. Mr. Speaker, I want to thank my colleague from Ohio, and I apologize that I came here late; but I am so glad the gentlewoman took the time so we did not lose it.

The dialogue that the two gentlewomen were having was really excellent. I know she has to leave; but I want to continue on, if I could, with my colleague from Florida on this generic issue, because I think it is so crucial, but I do thank the gentlewoman.

Mrs. JONES of Ohio. I thank the gentleman very much.

Mrs. THURMAN. I appreciate the dialogue too; it was great.

Mr. PALLONE. I noticed that my colleagues were talking about what I call the GAAP bill, Greater Access to Affordable Pharmaceuticals Act, or GAAP. I think it is important, and I want to kind of give my New Jersey perspective on this, because I agree with the gentlewoman completely when she said that the greater use of generics is certainly a way to address the affordability issue.

We have been talking in our health care task force and amongst Democrats about trying to put together a Medicare prescription drug benefit, and we have certain principles that we want to be universal: everybody should have it, should be voluntary, and it should be affordable. Because if it is not affordable, it is not much use to anybody. I agree with my colleague that in many ways, and I am not saying the two of us, but I think a lot of our colleagues have not paid enough attention to the whole issue of how generics and more widespread use of generics could really address that affordability issue in a major way.

Now, I say the New Jersey perspective because I have been kind of outraged by the fact that in my State, as the gentlewoman knows, there are a number of the brand-name drug companies, and I am very happy they are in my State, and we have a lot of people employed by them, but many of them over the years have approached me and other colleagues to try to put in these patent extensions. I have refused to sponsor patent extensions because I think it is wrong. I think what it effectively does is it postpones the day when the generics come to market, and it keeps the price artificially high using these brand names that have actually expired even under the law.

These things usually do not pass as stand-alone bills, as my colleague knows. They usually get stuck into some omnibus appropriations bill at the end of the session or some reconciliation or something else, and nobody even knows what they are voting on because it is a little paragraph somewhere in a bill that is 2 feet high on the desk. So that is something that has to stop, and the GAAP bill tries to address that.

The other thing we get is this whole issue of trying to change the patent. In other words, I will give an example. This is one of their favorite tactics that we get from some of the brand-name companies, and the gentlewoman may have already mentioned this, and I apologize.

Mrs. THURMAN. I did not.

Mr. PALLONE. They make essentially insignificant changes to the product, and they get a new patent just as the original patent is set to expire; and then they go on for years with essentially the same patent.

Mrs. THURMAN. And if the gentleman will yield, one of the things they do is they might change the label or how the medicine is configured; they might change the color. Now, they might have a problem with some of their medicines, because they do an awful lot of advertising on some called the purple pill. And there are a lot of folks out there that know the purple pill, so if they changed it to pink, I am not sure how many more they could sell. But that is the idea of what is going on out there.

It is not about the chemical makeup of this medicine; it is about just changing the label or color or whatever, but something that has nothing to do with the makeup of the medication at all.

Mr. PALLONE. And the way the current law reads, and I do not think it was really intended that way, but it has been basically utilized in the wrong way, that once that presentation is made with this new patent, for 30 months the generic cannot come to market. That is 30 months. We are talking about 2½ years, which is incredible; and we correct that in the bill that we talked about. In the GAAP bill we correct that.

Mrs. THURMAN. Yes. And we also correct a somewhat curious operation where they have actually kind of been involved or engaged with some generic companies where they actually have bought out or have actually delayed the generic drug coming to the market as well, and that is another area that we are trying to address in this piece of legislation.

Let me ask the gentleman a question, because I do not have this information, and I wish the gentlewoman from Ohio (Mrs. JONES) was back here, because one of the things we did not talk about that I think is also very important, and certainly the gentleman and I have looked at this and the research, but this whole issue of the profits. Because one of the things that the American people are being told at this time and have been told, and by the way through rather large marketing of political statements to the tune of about $30 million in this last campaign to try to persuade people to believe, that there were things that ought not to happen in a benefit plan. And I quite frankly was offended in some of the tactics that were taken in scaring people as to what might have happened.

But when we look at the profits and we start to do the breakdown, and I think Forbes came out with this, and I do not have it with me; but they were like four or five top parts, like profits or whatever. But, anyway, they had like three or four columns; and the pharmaceutical companies were top in every one of them in terms of profits, and then in the fourth column it was oil and gas.

□ 1930

So it was kind of ironic to me that here we are looking at issues, and I know in my home State and I think in all of our home States, is a life-or-death situation for many people. I do not know if the gentleman has those numbers.

Mr. PALLONE. Mr. Speaker, I do not have them with me, but in the last 6 months we have seen a lot of stocks tumble, generally in Internet and other areas. The drug stocks have stayed pretty good, primarily because they are making record profits. We are capitalists in America. And we do not have a problem with people making money, but they are making money at the expense of these seniors who cannot afford to pay for these prescription drugs. And as the gentlewoman says, it is a life-or-death situation.

During the course of the last Presidential campaign, as well as congressional races, we saw the current President, as well as many of our Republican colleagues, run on a platform that they were going to address prescription drugs and have some kind of benefit. We are not seeing it.

At one point, the President said that he wanted to do a low-income benefit. We are not sure if that is what he ultimately will say that he wants the Congress to do. At this point, I wish he would do anything. The idea of doing a low-income benefit is not what I am hearing from my constituents. The people that are coming to me are not the people that are eligible for Medicaid, but the people in the middle-income bracket that do not have a benefit because the HMO does not provide it, or they want to buy some Medigap which does not cover it. They are going without. They are doing as the gentlewoman from Ohio and the gentlewoman from Florida said, they are cutting back or taking half a pill or just not getting any pill.

I agree with the gentlewoman that generics is one way to address this, but we need a benefit package. We have to say that everyone that is covered by Medicare, regardless of income, gets a prescription drug benefit. We figure out how to do it and whether there is going to be a co-pay and what the catastrophic is. I do not see that happening with the Republican leadership. I do not see any movement in that direction.

Mrs. THURMAN. Mr. Speaker, the only movement that we have seen or has been talked about is the $157 billion that would be used, as suggested, for low-income seniors. In Florida, we already have a Medicaid medical-needy program for those in that position. The gentleman is correct, it is in the middle and at the high. The issue there as well, and quite frankly an issue I have with the entire Medicare situation, some people have it because they have Medicare Choice, but we are seeing Medicare Choice programs are pulling out, and then these folks have no prescription drug benefit.

But at the same time, if an individual is a fee-for-service Medicare beneficiary, they have paid in exactly the same thing on a tax on earnings to provide for Medicare, and the money that goes into HMO Medicare Choices are nothing more than the tax dollars which have been put in there and then given to the Medicare Choice programs to provide this.

So you have a very unbalanced Medicare beneficiary program going on where some get it and some do not. Some are getting pulled out, and they have nothing to replace it with. When you look at the Medigap programs, and we have all heard and seen, and certainly from the stories we hear from our constituents, Mr. Speaker, they might pay $1,800 a year, but they might only get $1,000 in benefits. That is part of what is going on out there.

When we started looking at this last year, we said it has to be a Medicare benefit. It cannot be through some private benefit because we had all of the insurance companies, or at least many of them come and say, guess what, we are not going to provide this. On top of that, you dilute the buying power of the Federal Government for a benefit package. And that is where a lot of discussion is going on right now in the health care caucus that we have been talking about in trying to come up with some alternatives. Those are some issues that we are all trying to wrap-around and figure out what to do with them here; but the gentleman's State has a better start.

When I talked about the medical needy or the Helping Hand Up, quite frankly, part of that plan was to give back to the governors.

Mr. PALLONE. Mr. Speaker, that is a block grant.

As the gentlewoman says, every one of these proposals that the Bush administration comes up with, the people that they are supposed to help say they are not going to work.

My own State, Mr. Speaker, if an individual is eligible for Medicaid and is very low income, they usually get their drugs. There are problems, I am not saying it is easy, but generally they have access. Because we have casinos, there is revenue that is generated by the casinos that goes to the State, and we use that to finance a lower income prescription drug benefit that is above the people eligible for Medicaid.

Right now I think that is maybe as high as, for a family of 2, maybe up to $19,000 or $20,000 annually; and that is very good because you only have to pay $5, I think, for each prescription.

Mrs. THURMAN. Mr. Speaker, if the gentleman would yield, who does this?

Mr. PALLONE. Mr. Speaker, the State does with the casino revenue funds. That has been going on for awhile, but that does not cover the majority of seniors or the majority of middle-income seniors. Those are the people I hear from. New Jersey has a high cost of living. When one talks about $16,000, $17,000, $18,000, $19,000, one cannot live on it in most cases.

As the gentlewoman said, we have heard two things from the Republicans. One is the Bush proposal which is the Helping Hand. I have in front of me, he says that the measure establishes block grants for States to provide prescription coverage for some low-income seniors. His plan limits full prescription coverage to Medicare beneficiaries with incomes up to 35 percent above the poverty level, up to $11,600 for individuals and $15,700 for couples. That is below what New Jersey is already offering with the casino revenue. We would not benefit at all, and that is obviously why in our State nobody is in favor of this.

Mr. Speaker, the other thing that we are getting was this idea about the Republican proposal last session which is the drugs-only policy. In other words, rather than have prescription drugs as a benefit under Medicare for everyone, which the gentlewoman and I propose, and the Democrats propose, they would just give a certain amount of money and you go out with a voucher and buy a drugs-only policy. But as the gentlewoman said, no insurance company says they are going to write it.

Mr. Speaker, I know in Nevada they actually did that about a year ago. For 6 months they could not get anybody to write it. Then somebody wrote it, but I do not think that they covered even 100 people. It was a total failure.

So these approaches, it is almost like let us do whatever we can not to guarantee this under Medicare because Medicare is somehow evil or government. I do not have any patience for people who get into the ideology of whether it has to be government run or not. The only thing I care about is whether it works practically. I do not care about the ideology myself.

Mrs. THURMAN. Mr. Speaker, I think that the governors got together. I believe this is what happened.

Mr. PALLONE. Mr. Speaker, the gentlewoman is correct.

Mrs. THURMAN. And they talked about it. One of the things that they do not want to do is they do not want to be in the position of taking over the Medicare program. They already are involved in the Medicaid program, plus whatever programs they have within

their own States, and they do not want this responsibility.

Then they have to pick and choose. They have to make that determination. Quite frankly, that is a very bipartisan group of folks out there. That is Democrats, Republicans, Independents, making that decision not to have the Federal Government abrogate to the States our responsibility which is Medicare.

Mr. PALLONE. Mr. Speaker, that is an important point. The problem with the block grant, if you use my State, you can write into this language that would not allow this, but there is the danger that you send the block grant to the State and they use the money to fund the program already there. You can try to avoid that through legislation, but it is always going to be a problem. If there is not enough money, they use it for the existing program and do not expand it to include anybody else.

Mrs. THURMAN. Mr. Speaker, at the Federal Government we are already participating with the Medicaid program.

Mr. Speaker, somebody gave me a note to tell me what those three subtitles were on the profits. I will go back to that. Number one, return on revenue. Number one, return on assets. Number two, return to the shareholder equity. That is what they were actually in the last look in the last time. I thought that was pretty interesting.

And I agree with the gentleman from New Jersey (Mr. PALLONE). I give the gentleman a lot of credit because I know he has a lot of pharmaceuticals, and the gentleman is bucking those people at home who do provide jobs. So I give the gentleman a lot of credit for standing up on principle and on an issue that he believes in. The gentleman has done a tremendous amount of work. It is not easy, especially when one looks at the dollars spent on things like Flo, and some of the ads attacking us because we have this belief that people ought to have a Medicare prescription drug benefit. But it is important.

Mr. PALLONE. Mr. Speaker, the gentlewoman is correct that so much money has been spent, and of course New Jersey does have a lot of the brand name drug companies. But if you talk to people on the street in my State, their attitude is not any different. They do not have any better access or ability to purchase the drugs than anybody else; so the problems are the same wherever you are.

Mrs. THURMAN. Mr. Speaker, here is another issue, and this hits everybody. This is not just a Medicare patient, this is now starting to hit families, working men and women across this country. I actually got the first taste of it about a year ago when a major corporation came in to talk to me about this. They were talking about health care costs going up. I said, Tell me what that means. They said, Well, our prescription drug benefit is going up so high and the cost of the drugs are getting so high that we have a couple of choices now. We can either reduce the benefits of a prescription drug, or we can no longer or we will not be able to actually do coverage of other areas of health care.

Mr. Speaker, if a business had a plan where they were given some dental or they might have been given some mental health or they might have had for their child an ear examination or a woman might have had a pap smear, mammography every year, now they are changing those plans to meet the needs in the prescription drug part of it, and they are now cutting back on the other benefits of these plans. It is all because of one area within health care that is really pushing this up.

That worries me because here we are talking about all of the uninsured, the 44 million people that are uninsured. We are trying to find ways in this Congress to actually make it easier and beneficial to employers to provide health care. Then once they get into it, and what people are looking for in a plan is not going to be available to them because of one cost over here. So it could just eventually escalate.

The same thing is happening in the hospital system. They do have some reimbursement for Medicare within the hospital setting, but in some of these other insurance companies as they cut and are not available, there is nothing we can do about it. Their costs are starting to go up. So then it is a domino effect. If you have to do this, what are you going to do about nurses, what do you do about the shortages we are having? There are all of these domino effects to the health care system.

Mr. Speaker, I do not think that any of us want to see the pharmaceutical companies go out of business. My husband had a kidney transplant in 1995–1996. If the medicines like immunosuppressant drugs were not available, transplants might not be as easily done because this medicine works as an anti-rejection.

□ 1945

I can tell you how thankful I am that I have my husband, and I am thankful for the research they have done. But we cannot just hang that out, because there are so many things going on out there that just have not been proven to us, at least have not been proven to me that in fact they could not give a little to our constituents who do not have the opportunity to have a prescription drug benefit at this point.

Mr. PALLONE. I want to pick up on the gentlewoman's point there about how as the prescription drug part of health insurance, as the cost continues to rise, and you have, as you say, either cutbacks in other areas or just costs that make it prohibitive for employers to cover their employees, that is the crux of the problem. We had as a percentage of the population fewer people that were uninsured a few years ago than we do now, mainly because the primary way that people were insured historically in this country was through their employer, on the job. And when you create a situation where those employers can no longer cover their employees, that is where the crisis comes with the uninsured. Again, I do not want to look at it ideologically. In my view I would love to have everybody covered by their employer and not have to have any Federal program. But we know that the problem now again is not people who are on Medicaid or people who are low income, who are not working because they are disabled or they cannot find a job, the problem is for people who are working. The uninsured, that 45 million people, they are almost all people that are working.

Again I say, I have been as strong an advocate as the gentlewoman of expanding some of these Federal programs to the uninsured, as most of the Democrats have. We initiated the CHIP program for kids, which basically gives money to the States so that they can insure children, and we have advocated as Democrats that we would like to see CHIP expanded to the parents so that the parents who are working do not just enroll their kids but can enroll themselves. Again, we have had the Republican leadership and the President, I would not say oppose it completely, but certainly not been supportive. They have granted waivers to certain States in a minimal way to do it, but most States do not have waivers. What we really need is a program that covers everybody who is eligible for the CHIP program, be they a parent or even a single person. I do not think they should have to be a parent either. I think even a single person who is in that situation.

Again, I do not advocate that because I think that the government should run health care or because I want a government program to provide insurance, but simply because the employers cannot do it anymore. That is why we have had this shift to so many people who do not have health insurance.

I agree with the gentlewoman that the drug companies, to the extent that they are making these big profits, they are contributing to the inability of employers to pay for health insurance or to make a significant enough contribution to make it so that employees can take advantage of it.

Mrs. THURMAN. That is what we are hearing at home. It really is kind of sad.

I think maybe we should jump over just to one other issue quickly because I think we might even have an opportunity either this week or next week to look at something also that has been

on a lot of people's minds and that is the Patients' Bill of Rights, another issue that has been around since about 1999, 1998, that quite frankly passed this House in a present form that we could take up today, pass it and move it over to the Senate with a very similar piece of legislation and we could be putting the Patients' Bill of Rights on the President's desk. However, once again, and I heard some stuff today that I need to check out, but some of the things that are going to be stuck in this, like maybe some MSA stuff and some other areas that are going to make it kind of bog down again. This is such a critical issue in so many ways.

One of the stories that I always tell and actually came from one of the editors of my newspapers who said, tell me about the Patients' Bill of Rights. We said, well, this would give the opportunity for children to go to their pediatricians and women to go to their obstetricians and all of these abilities for us to have a little bit of choice in our programs and who the doctor might be. But I think the underlying issue is somebody taking the responsibility of a mistake being made, because quite frankly when you have to take responsibility, less mistakes are made. I honestly believe that that is what this issue is really all about.

One of my editors was telling me about a young woman that his daughter was going to school with. What happened was she went in for a breast exam, had a lump, and the doctor asked to have a mammogram done. They said, no, that she is too young, that she is not going to have breast cancer and on and on. The doctor said, no, you need to do this.

They did not get it. Six months later she went back, the same thing, did not get it. Finally she came home for Thanksgiving or something, her parents said, we really need to get you to this doctor. They went, they did a check on it and in fact it was cancerous. It was my understanding that she may not live because of this. That was someone's responsibility. The doctor made the decision and somebody denied that care.

Now, what really strikes me, though, is if the doctors do that under liability as we know today, they would have to be held accountable and in many cases they become the ones who are held accountable for a decision that they made to have it done but somebody else told them no.

Mr. PALLONE. Because they were told that if they have so many tests or if they have too many costs, then they are going to not be part of the plan and they will not be able to practice medicine essentially. It is very sad.

Mrs. THURMAN. Hopefully we will have a good, clean bill and a good, clean debate on this floor.

Mr. PALLONE. I wanted to point out, and the gentlewoman said it earlier on, but I want to reiterate it, and again I am being very partisan, but I have been very frustrated because if there was one health care issue that during the course of the presidential campaign the current President, then candidate George W. Bush, said was that he wanted to pass a Patients' Bill of Rights and even mentioned how in the State of Texas that they had a Patients' Bill of Rights. He forgot to mention that he did not sign it and he let it become law, but we will forget about that for the time being. The bottom line is that the first thing that many of us did who supported a Patients' Bill of Rights, the first day we were here in session in January, on a bipartisan basis, there were just as many Republicans as Democrats, put in the bipartisan Patients' Bill of Rights, exactly the same as the Texas law, and said, ''Okay, here is the bill. Let's get it going. Let's get it signed.''

The gentleman from Michigan (Mr. DINGELL) took the lead on the Democratic side, the gentleman from Iowa (Mr. GANSKE) on the Republican side. I guess I am not supposed to mention the other body, but I will say it was bipartisan in the other body as well. Six months have passed almost and what has happened? Nothing. I understand that the other body is going to take this up because of the change in the party, Democrats are now in control in the other body and they supposedly are going to take this up, but we should not have to wait for a party change for that to happen.

And what is wrong with doing it here in the House of Representatives? As you said, this bill, the Ganske-Dingell bill, is almost exactly the same as what passed overwhelmingly here in the last session with almost every Democrat and I think about a third of the Republicans, and the President now says, ''Well, I don't like it too much. I may want to change which court you sue in.'' He has got a couple of things. In my opinion, they are relatively minor. I honestly believe that if you took the proponents of the two parties on this issue and you sat them down in the well here tonight, they would be able to iron out their differences in an hour and we could bring the bill up tomorrow. The President is really dragging his feet on this and the Republican leadership is dragging their feet because they do not want it to be brought up because they know if it does as last year, it will be passed overwhelmingly.

I hear, though, that there is a movement on, and I will not get into too many details but some of the Republicans on the Committee on Ways and Means, the gentlewoman's committee, to try to come up with an alternative bill that is a lot weaker, that actually does not cover everybody, covers a smaller group, not everybody or does not even provide some of the basic protections. I would hate to see any watering down in that respect, because we clearly have a majority here that wants a strong, real Patients' Bill of Rights. We need to keep everybody's feet to the fire and say, ''That's a bill that's going to get out of here.''

Mrs. THURMAN. We talked about this a couple of weeks ago. I actually went back and looked at the vote. The vote was overwhelming. Not only on top of the vote being overwhelmingly bipartisan, also instructions to the conferees, because remembering that the House passed it, the Senate passed it, it was in conference, but it was never allowed to get out. The President at that time, Mr. Clinton, was ready to sign the bill. They could never come to agreement. It was all over this issue of responsibility, which I find extremely interesting because any other mention of any other issue, they keep telling that we need to take personal responsibility. Why would you not expect an HMO to take personal responsibility for decisions they make any different than you would ask an individual to take personal responsibility?

So here it is, 2001, potentially we will have this opportunity. I would hope that our colleagues who supported the Dingell-Ganske-Norwood bill would be in favor of also getting this done in a prompt time and let us get it to the President and then he can make the decision as to what he wants to do. I am not trying to do that, I am just trying to make sure that in fact the people that we represent are given the options that they have been asking for since 1998. Because, quite frankly, we have done a lot of other things for the hospitals, we have done it for managed care in this last go-around, we have worked on some of the issues, the money issues, we have tried to be fair and balanced in all of the kind of revenue bills we have done, the appropriations, the revenue bills we have done over the last couple of years when money was cut out of Medicare, to kind of pump that back up. They all got some of it. Now we are just saying, ''Okay, let's be responsible and let's do the right thing for the people.''

Mr. PALLONE. I will be honest with the gentlewoman, I am totally convinced that anything that comes to the floor somehow procedurally, the majority's will will prevail and we will be able to get a good bill. Even if the Republican leadership comes with a bad bill to the floor, we will do amendments, we will do substitutes, we will do whatever and we will be able to overcome it and come up with a good bill. I am just afraid we never see it. That I think is again the special interest, the health insurance industry, which unfortunately does not want to see the changes that this bill does. Basically what the bill does, if you want to sum it up in maybe one or two sentences, is it says that decisions about

what kind of medical care you are going to get, what is medically necessary, are made not by the insurance company but by the physician and the patient. They do not want that. The second thing is that if you are denied, as you mentioned, that you have a legitimate way to express your grievance, either through an independent, outside board or to go to court, and they do not want that, either. Naturally the insurance companies are going to oppose this and they are going to try to do whatever they can to prevent it from coming up here in a fashion that we really can vote as a majority for what we think is good for the country. But we will just keep speaking out as we have until we see something come forward that we know is good for the American people.

Mrs. THURMAN. I have enjoyed this. I hope some people have been listening. We certainly would love to hear their comments or their stories or issues that make a difference in people's lives, because I think it is important that we hear from the real people out there that have to deal under the laws that we either pass or do not pass in some cases.

Mr. PALLONE. I agree. I want to thank the gentlewoman for being here tonight as she has so many times. I think all we are really trying to do is what is right for the average American. These health care issues are really crying out for a solution. It is not pie in the sky, it is real, day-to-day lives that people are living and it impacts on their lives.

ADMINISTRATION'S ENERGY POLICY TO BENEFIT THE ENVIRONMENT AND AGRICULTURE

The SPEAKER pro tempore (Mr. GRUCCI). Under the Speaker's announced policy of January 3, 2001, the gentleman from Minnesota (Mr. GUTKNECHT) is recognized for 60 minutes as the designee of the majority leader.

Mr. GUTKNECHT. Mr. Speaker, I am joined tonight by some of my colleagues, and we are going to talk about what I think is a very happy thing that happened today. It is a happy coincidence where good policy comes together, when we are talking about energy policy, we are talking about environmental policy, and ultimately also talking about what is good for American agriculture. All three of those things came together today when the White House announced that they are not going to give California a waiver of the clean air standards in terms of oxygenated fuel.

We have got a number of experts who are going to talk tonight. I know some of my colleagues have other things that they need to be at and so I want to first of all recognize the gentleman from Illinois (Mr. SHIMKUS), who has been really one of the stalwart fighters in the battle for oxygenated fuels, for biofuels, for making certain that wherever possible we grow the energy that we need here in the United States. I want to welcome him to the special order tonight. I know he has got somewhere else that he needs to be tonight. I thank the gentleman for joining us.

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Mr. SHIMKUS. Mr. Speaker, I thank the gentleman from Minnesota (Mr. GUTKNECHT). We have folks from Minnesota, Nebraska, Iowa, and I am from Illinois. It is a great day.

I will take kind of a different twist because many of the Members who will come up to speak will be from their position on the Committee on Agriculture or the Committee on Appropriations, and other committees that have an important role. I serve on the Committee on Commerce, and from that vantage point I have had an exciting time dealing with biofuels issues across this Nation, not only ethanol but also biodiesel.

The decision rendered by the EPA today on the California waiver request was a major victory for a couple of reasons. One, it is just a simple great victory for clean air. The Clean Air Act that was enacted into law in 1992 has had a significant impact on cleaning our air throughout this country. The greatest benefit is that 2 percent oxygen requirement that in essence just helps the fuel burn with more intensity and by burning with more intensity it then burns out the impurities. So we have some benefits.

We have a reduction in carbon monoxide at the tailpipe. We also have, in essence, a reduction in carbon dioxide because ethanol and the 2 percent quality is replacing petroleum-based fossil fuels, which is decreasing the carbon dioxide. So we are having tremendous benefits.

Let us talk about it from just the overall energy issue. We have and still have an increased reliance on foreign imported oil. It is very critical to our national strategic energy policy to make sure that we have the ability internally to produce the fuels that we need to create the energy sources to help development in all aspects, and also to have the fuel resources we need to go to war. If we continue to rely solely on one fuel type, petroleum-based fuels, and not explore renewable fuels, then we put ourselves at a disadvantage.

What this California waiver decision does is it establishes for the capital markets and for all the co-ops and all the producers who have been anxiously awaiting some certainty that ethanol is going to have a role in our national energy policy, that there will be some certainty in their investments.

California is a tremendous market, a market that has been primarily filled, the oxygen portion, by MTBE. MTBE has been known to pollute groundwaters and is now becoming the additive persona non grata. No one wants to use it. Ethanol creates a win/win for us because it helps us keep the clean air standards that were passed that have been so successful while ensuring that we have clean water since ethanol does not pollute the groundwater.

This will also translate into an increased demand for our producers, certainty to the markets for the capital investments and as I have talked to a lot of my producers and the folks in the agricultural industry, the most important thing that this administration could have done was to deny the California waiver, keep the clean air and push for the continued use of the oxygenation standard and that oxygenation standard being the use of ethanol. It is a tremendous victory. I applaud the administration on keeping a proper balance with clean air and clean water and also putting a hand out to our family farmers who have for many, many years invested in a product that they know can meet the demands of the future and have cleaner air.

This sends a strong signal to the agricultural sector that ethanol is here to stay and now we can use this victory to leverage an increasing biofuel usage across the board, maybe a renewable standard, also working in the biodiesel aspect with the soy, soy diesel aspects that I have worked through in other legislation.

I wanted to make sure that I had an opportunity to come on the floor to reemphasize the importance of what the administration has done today, and I thank the gentleman from Minnesota (Mr. GUTKNECHT) for arranging this special order and yielding me the time.

Mr. GUTKNECHT. Well, I thank the gentleman from Illinois (Mr. SHIMKUS) for his remarks. He has been afire on this issue in terms of biofuels, and we worked with the gentleman on not only this but ultimately moving forward with biodiesel, a product that can be made with a blend of diesel fuel and soybean oil or other oils. Soybeans seem to work the best. These are ways that we can help solve our energy problems by growing more of that energy supply.

I want to just come back to one point that the gentleman made about MTBEs. Now, we know that MTBEs cause cancer. We also know that it leaches into the groundwater. The reason that ethanol is such a great product in terms of replacing it really is twofold. First of all, we know that ethanol is harmless to people. As a matter of fact, if one puts it in an oak barrel for 7 years, many people enjoy it in the form of bourbon, a modified version of whiskey. So it is something that actually can be consumed by human beings, and it is consumed by human beings.

More importantly, it is actually cheaper than the MTBE. Let me just